615.859.SKIN (7546) | f: 615.851.7760
www.LovenDermatology.com

Patient Authorization for Release of Protected Health Information

By signing this authorization, I authorize Loven Dermatology to use and/or disclose certain protected health information (PHI) about me to the party listed below.

□ Release from: Loven Dermatology, PLLC Phone: 615.859.7546
□ Release to: 201 Bluebird Drive Fax: 615.851.7760
Goodlettsville, TN 37072

□ Release from: ___________________________ Phone:_________________
□ Release to:
Address:____________________ Fax:____________________

____

Specific individually identifiable health information to be released is listed below. (date(s) of service, level of detail to be released, origin of information, etc.)

□ All records If other, specify: ____

If you do not want certain portions of your medial records released, please initial the spaces below. Leave blank if this does not apply to your request.

______AIDS/HIV ______Substance Abuse ______Psychiatric Conditions ______Other (Please Specify)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclose by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent the Loven Dermatology has acted in reliance upon this authorization. My written revocation must be submitted to Loven Dermatology, Privacy Officer, 201 Bluebird Drive Goodlettsville, TN 37072.

Patient Name:___________________________________ DOB:______________________________

Signature:_______________________________________ Date:______________________________